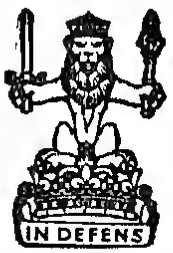
DEPARTMENT OF HEALTH FOR SCOTLAND
SCOTTISH HEALTH SERVICES COUNCIL

MENTAL HEALTH LEGISLATION

Report by a Committee appointed by the Council



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* Because of illness, Mr. Taylor had to give up his duties as assessor in the course of the Committee's deliberations; his place was taken by Mr. T. B. Skinner.

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Mental Health Legislation

General Introduction

1. At the meeting of the Scottish Health Services Council on 25th September, 1957 we were appointed as a Committee with the following terms of reference:

"To consider the application to Scotland of the major recommendations in the Report of the Royal Commission on the Law relating to Mental Illness and Mental Deficiency in England and Wales (Cmnd. 169)* in the light of the White Paper on the Law relating to Mental Illness and Mental Deficiency in Scotland (Cmd. 9623)†; and to make recommendations."

2. We have held 6 meetings. We did not consider it appropriate to take evidence, but we had the benefit of the attendance at one of our meetings of Dr. R. C. MacGillivray, Group Physician Superintendent of the Board of Management for Lennox Castle and Associated Institutions, who gave us useful information about current practice—both in Scotland and in England—in a number of matters relating to mental deficiency.

3. We have interpreted our remit as requiring us to consider the Royal Commission's recommendations in only the broadest way, and we have not attempted to consider the detailed implications of our own recommendations; the limited time at our disposal would in any event have made this impracticable. We should also make it clear that our terms of reference do not require us to deal with matters coming within the purview of the Criminal Justice Acts.

4. The first topic with which we shall deal is of major importance:

Revised classification and nomenclature of mental disorder, including introduction of psychopathic group

(R.C. Report, paragraphs 185-198; White Paper, paragraph 35)

5. We recognise that certain groups of mentally disordered patients, commonly called psychopaths, present a special problem for which provision needs to be made. We are anxious that patients in these groups who would benefit from care and treatment in hospital or in the community should be afforded these, and we hope that the proposals we make will cover such patients.

6. Using the term in the currently accepted medical sense, and not in the sense suggested by the Royal Commission, we envisage that psychopathic patients would be treated in any one of the following ways:

(*a*) on a voluntary basis in any appropriate hospital or in the community;

(*b*) as a mentally ill patient subject to compulsory treatment;

(*c*) as a mentally defective patient subject to compulsory treatment, but only if exhibiting retardation of intellect and of emotional or social development;

(*d*) as a person committed by the Courts.

* Cmnd. 169 H.M.S.O. Price 10*s.* 6*d.* net. † Cmd. 9623 H.M.S.O. Price 9*d.* net.

7. With no designation of hospitals (which we suggest in paragraph 18 of our report) psychopathic patients could thus be treated in any unit providing for the care and treatment of the mentally disordered.

8. We do not agree, however:

(*a*) that all high-grade mental defectives should be regarded as psychopaths; or

(*b*) that the procedure for compulsory admission to hospital or guardianship should be used for anyone who is not medically recognised as mentally ill or mentally defective, except in the special circumstances to which we refer in paragraph 25 of our report.

9. Our reasons for dissenting from the Royal Commission's proposal to introduce a separate psychopathic group are as follows:

(*a*) The term " psychopathic " has already come to have so many meanings that it has almost no medical significance. The introduction of yet another meaning would add to the confusion already existing.

(*b*) The problem of " stigma " is not solved by substituting " psychopathic" for " mental defective." Both inevitably give the impression of an enduring, relatively unalterable state.

(*c*) It is agreed that there are many disordered persons needing institutional or community care who are not insane or mentally defective as these terms are at present used, and it should be recognised that most psychiatrists in mental hospitals and mental deficiency institutions find that patients exhibiting primarily a severe behaviour disturbance of an anti-social or violent nature are unsuitable for treatment in their institutions. In this sense we recognise a " psychopathic " group, but it is not necessary in our view to define the group separately from mental illness or mental deficiency, since most who can benefit from psychiatric treatment or care could be included under one or other head. To deal adequately with the psychopathic group, in the sense we have just used, it will be necessary, in addition to using existing mental hospitals and mental deficiency institutions, to set up special units, both under the National Health Service and the penal system, to which individual cases can be sent as appropriate.

(*d*) Since the Royal Commission say that no terms or definitions need in future be written into the law, except in connection with compulsion, it seems undesirable to add a new category of mental disorder purely for the purpose of compulsion when the aim is to reduce the use of compulsion.

10. Accordingly we recommend that there should continue to be two, instead of three, categories of mental disorder.

Introduction to other topics

11. We approached the problems with which we now deal with the wish—firstly—that Scottish law and practice should be as similar as possible to law and practice in England and—secondly—that the best traditional features of Scottish law and practice should be preserved. These two objectives proved to be not entirely compatible, and as our deliberations progressed we formed the view that certain features of the law in Scotland were—for Scotland—more satisfactory than their English equivalents, and that we were not justified in seeking uniformity by sacrificing provisions which have worked well in Scotland and in which the public have confidence. We refer in particular to:

(*a*) the safeguards created by applications to the sheriff for, and appeals to him against, detention under compulsory powers, which apparently work well in practice and which have not given rise to criticisms such as have been made by the Royal Commission of the equivalent English procedures before justices and magistrates;

(*b*) the very much more limited powers of laymen in Scotland in respect of discharge of mental patients;

(*c*) the more intimate connection which exists in Scotland between the General Board of Control on the one hand and the mental and mental deficiency services on the other.

The General Board of Control for Scotland

12. Since many of the recommendations we shall be making in subsequent parts of our report imply the continued existence of the General Board of Control, we think it well to say at the outset that we do contemplate this, and to make clear what we think the future role of the Board should be.

13. As we have indicated in paragraph 11, the Board have had in Scotland over the past century a very close relationship both with the staff of the mental and mental deficiency services and with the patients, who show special appreciation of the interest taken in them by the Board's visiting Commissioners: in particular, the guardianship system in Scotland has been facilitated by the Board's relationship with patients so placed. This situation may have arisen partly because of the small number of patients and hospitals with whom the Board in Scotland have had to deal. It is clear to us that this relationship is something of real value to patients, and one which should not be abandoned except for very strong reasons.

14. The Board of Control are a completely independent body whose main function is the safeguarding of patients' interests. Patients, doctors and the public have great confidence in the Board acting in this capacity. In accordance with our general view that voluntary patients should be treated as far as possible like ordinary patients, the Board's main work in future would be in respect of those who are detained compulsorily. The Board should have the right of access to full information about the identity and whereabouts of such patients. They should also, however, retain the right of access to any person, whether in hospital or elsewhere, who they have reason to believe may be unable, owing to his mental condition, to look after his own interests and may be subject to improper treatment.

15. At the present time, however, the Medical Commissioners of the Board have a dual role, since they not only carry out duties to safeguard patients' interests, but also discharge advisory functions as officers of the Department of Health for Scotland. We think that this is an undesirable situation in that the people concerned are obliged to look at problems from two different stand-points; they are asked to play, on the one hand, the part of " referee " in matters affecting patients' interests, and, on the other, that of " centre forward " in the Secretary of State's mental health team. These roles are not always consistent, and we recommend that, if possible, the duties of the Medical Commissioners should be confined to the activities of the Board.

16. In the Appendix to our report we make more detailed observations on some of the functions and powers which the Board have at present.

Voluntary admission and discharge without formality

(R.C. Report, paragraphs 216-229 and 287-306; White Paper, paragraph 5)

17. Under this head we are unreservedly of the view that:

(*a*) The general principle should be in future that patients suffering from all forms of mental disorder should be admitted, treated and discharged as far as possible like patients in a general hospital. (We should expect that in matters such as the administration of anaesthetics and the use of types of treatment to which an element of danger attaches, the ordinary safeguards for obtaining consent would be observed).

(*b*) We recommend in particular:

(i) that the present written application for admission and the present three days' notice of intention to leave should be abandoned;

(ii) that the recommendation in (i) should apply to all forms of mental disorder and to patients under 16 as well as over 16;

(iii) that statutory notification to the central authority should be abandoned.

No designation of mental hospitals

(R.C. Report, paragraphs 291 and 378-9)

18. We recommend that the designation by the Secretary of State under the National Health Service (Scotland) Act, 1947, of mental hospitals and mental deficiency institutions should be abandoned.

19. Instead, Regional Hospital Boards should decide in which hospitals and institutions accommodation will be made available for the reception of patients under compulsory powers, and should notify the General Board of Control.

20. The use of the word "mental" in the names of hospitals should generally be discontinued, as also in the official titles of Boards of Management responsible for mental hospitals.

21. We recommend that the use of the word "institution" should be discontinued in relation to mental defectives.

22. The abandonment of designation will help to relax the present rigid separation of mental hospitals and mental deficiency institutions. This, we consider, would be a desirable development since in future there should be no impediment to freedom of movement among places where the mentally disordered are cared for.

Scope of compulsory admission

(R.C. Report, paragraphs 319-356)

23. For the purposes of compulsion, we recommend that the conditions which should have to be satisfied when seeking a judicial order from the sheriff—which we recommend in paragraph 30 should continue to be done—should be as follows:

(a) Mentally Ill Patients

(1) Both doctors recommending admission should be satisfied in conscience:

(*a*) that the patient suffers from a recognised mental illness. The grounds on which the opinion is based should also be briefly stated. (We recommend in paragraph 32 that one of the doctors should be approved as an expert in this subject); and

(*b*) (i) that the patient is in need of treatment, care or protection that can only be given in an approved hospital, or in the community under approved direction or (ii) that he is a danger to others.

(2) Both doctors should state why it is not possible or desirable for the patient to accept this treatment, care or protection on a voluntary basis.

(3) Accommodation or provision should be available for appropriate care and treatment.

(b) Mentally Defective Patients

(1) Both doctors recommending admission should be satisfied in conscience that the patient shows such a degree of retardation of intellect and of emotional or social development (*a*) that he requires treatment, care or protection for himself in an approved hospital, or in the community under approved direction, or (*b*) that he is a danger to others. The grounds on which this opinion is based should be briefly stated and, as in the case of the mentally ill, one of the doctors should be approved as an expert.

(2) Both doctors should state why it is not possible or desirable for the patient to accept this treatment, care or protection on a voluntary basis.

(3) Accommodation or provision should be available for appropriate care and treatment.

24. We have considered the Royal Commission's suggestion that it would be helpful to have compulsory powers available by which mentally ill patients and high-grade mental defectives could be admitted to hospital for up to 28 days' observation and preliminary treatment. We have reached the conclusion that this suggestion should not be adopted in Scotland in respect of the mentally ill: our reasons are as follows.

(*a*) We consider that our proposals for facilitating voluntary admission reduce in substantial measure the case for introduction of the 28 days' period.

(*b*) The suggested procedure could benefit only relatively few patients, whereas, if misused, it could work to the detriment of many.

(*c*) We could not contemplate the introduction of such a procedure without the participation in it of the sheriff, and a judicial order for a restricted period would not appear to have much point.

25. On the other hand, although it is not within our remit to make recommendations regarding the criminal code, we consider that in respect of persons who have appeared before the courts and whose mental condition requires observation there would be advantage in the procedure suggested by the Royal Commission for compulsory admission to hospital for up to 28 days' observation and preliminary treatment.

26. At present there is no statutory definition of mental illness. In practice the certifying doctors must state that the patient is a lunatic, or an insane person, or a person of unsound mind, and a proper person to be detained under care and treatment. This opinion must be supported by facts observed by himself and facts communicated to him by others. The form of the certificate is specified in Schedule D to the Lunacy (Scotland) Act of 1857. What we recommend in paragraph 23a does not involve abandoning the Schedule, but it is hoped, would encourage the making of a more general report on the

condition of the patient, the need for care and treatment, and the reasons for compulsion. The proposed new requirements would keep before both the doctors and the sheriff operating the procedure the general principles on which it is based.

27. We should like to say that we endorse certain of the suggestions made by the Royal Commission for the treatment of the problem of high-grade mental defectives, although we do not share their view that these patients should form part of the proposed psychopathic group. These suggestions are:

(*a*) that in the case of the compulsory admission to hospital or guardianship of patients under the age of 21 at the time of admission, the compulsory powers should lapse when the patient reaches the age of 25 if he has not already been discharged, unless admission followed court proceedings or transfer from prison or approved school;

(*b*) that compulsory powers should be available in respect of patients over the age of 21 who are convicted of a criminal offence if the court before whom they are convicted (or the Secretary of State in the case of transfers from prison) is satisfied that ordinary penal measures alone are insufficient or inappropriate.

Procedure for compulsory admission (otherwise than in emergencies and other special circumstances) (a) when the patient is unwilling and (b) when the relatives are unwilling

(R.C. Report, paragraphs 401-406, 413-420, 491-510; White Paper, paragraphs 7, 8 and 15)

(a) When the patient is unwilling

28. The Royal Commission recommend that the application for a patient's compulsory admission to hospital or to the guardianship of a local health authority should be made by a relative or by a mental welfare officer of the local health authority with the support (except in emergencies) of two medical recommendations, but without reference to a judicial authority.

29. Except in circumstances where the emergency procedure is appropriate and in the circumstances described in paragraph 25, it seems wrong to us that where it is proposed to deprive a person of his liberty for any length of time no person or body other than the doctors should participate in dealing with the application; this seems particularly undesirable in cases where the application is made not by a relative but by a mental welfare officer, or where the two doctors are partners.

30. We have reached the conclusion that the further participant in the procedure should be, as at present, the sheriff. Our opinion is that the present procedure in Scotland whereby an application for compulsory admission has to be supported by a sheriff's warrant works very smoothly. We know of occasions when the sheriff has intervened properly by declining to grant a warrant, and we do not think that the procedure in itself causes any particular difficulties for relatives: we understand that relatives are troubled more by taking responsibility for initiating compulsory admission than by the fact that the application will find its way to the sheriff. We think that the sheriff is the most suitable person to consider applications for the use of compulsory powers (*a*) because he is readily accessible, and (*b*) because he is professionally qualified to assess the validity of judicial applications.

31. In the course of arriving at the conclusion in paragraph 30 we have considered:

(*a*) whether one of the recommending doctors should always be a psychiatrist; and

(*b*) whether the medical superintendent—or one of his staff—should be permitted or encouraged to sign or be debarred from signing a recommendation.

32. In seeking to reach conclusions on these matters our objective has been to find the best means (*a*) of achieving the soundest possible medical certification; and (*b*) of achieving a better link than we understand exists at present between certifying doctors and the medical superintendent of the hospital which the patient is destined to enter. It seems to us that both ends would be furthered by the two recommendations that follow:

(*a*) We recommend acceptance, subject to a proviso which we shall mention, of the Royal Commission's recommendation that one of the two medical recommendations for a patient's compulsory admission should be made by a doctor—preferably a psychiatrist—specially experienced in the diagnosis and treatment of mental disorders: we add our own recommendation that the General Board of Control should maintain a register of doctors whom they have approved for this purpose.

(*b*) We recommend that future legislation should make it possible for the approved doctor signing one of the certificates to be the medical superintendent or other medical officer of the receiving hospital.

33. The proviso to the first of these recommendations is that one of the certificates should be signed by an approved doctor **where this is practicable.** We insert this proviso because we appreciate that for some time to come there may not be a sufficient number of specially qualified doctors available to sign a certificate on every occasion, and also that there may sometimes be difficulty in obtaining the services of such a doctor in a remote area.

34. In support of the first of the above recommendations we contend that it is in the patient's interest that he should be seen by a doctor experienced as we have indicated who will be capable of making a more thorough and effective examination than a general practitioner and who may in certain cases be able to persuade the patient to enter hospital voluntarily—in our view a worthwhile achievement. It also seems to us that it would be satisfactory from the sheriff's point of view if he knew that one of the certificates had been signed by an approved doctor, and indeed we suggest for consideration that if one of the certificates is not so signed the sheriff should be told why.

35. In support of the second of the above recommendations we would only repeat what we have indicated above, namely that a provision of the kind contemplated would make for closer liaison between the certifying doctors and the superintendent of the receiving hospital.

36. We consider that, ideally, the medical decision as to compulsory admission should be taken by a psychiatrist who has perhaps been seeing the patient from time to time at an out-patient department or in his home, and by the patient's family doctor, who will be thoroughly conversant with his background. The procedure should in fact be in the nature of a domiciliary consultation wherever practicable.

37. We strongly deprecate however the practice in some areas whereby a local authority sends two medical members of their staff for the sole purpose of certifying a mentally ill patient—doctors who have never seen the patient before and are unlikely to see him again. A correct assessment is almost

impossible in any doubtful case. The practice to which we refer may on occasion be unavoidable, but it should be regarded as exceptional.

38. While a certain amount of what we say in paragraphs 32-37 is particularly appropriate to mentally ill patients, we intend our recommendations in these paragraphs to apply generally both to the mentally ill and the mentally defective.

(b) When the relatives are unwilling

39. Having regard to our recommendations on the subject of voluntary and compulsory admission, we think it unnecessary to make specific provision for circumstances in which the patient is willing but the relatives are unwilling. We recognise however that a difficult problem arises in respect of non-volitional patients, and particularly senile patients, who would benefit from admission to hospital but whose relatives object to their admission. In such circumstances we recommend the adoption of some procedure other than certification and on the lines of section 47 of the National Assistance Act, 1948.

Emergency procedure

40. We consider that the difficulties experienced in operating the present procedure for emergency admission would be overcome if there were extended from three days to seven the period during which a patient may be detained without a judicial order.

Persons holding powers of discharge at any time from compulsory detention

(R.C. Report, paragraphs 421-427; White Paper, paragraph 27)

41. We recommend retention of the Scottish statutory provision whereby the nearest relative may obtain discharge subject to a barring certificate by the superintendent and a right of appeal to the General Board of Control.

42. We recommend that the medical superintendent should in future have a power of discharge that is written into the law; at present he is only assumed to have this power.

43. Although we understand that it is seldom used, we recommend that Boards of Management should continue to have a power of discharge subject to a barring certificate by the superintendent and a right of appeal to the General Board of Control.

44. We recommend that a residual power of discharge should be held by a central body—namely the General Board of Control.

45. The above recommendations are intended to apply to mentally ill patients, but we think that the same principles should in future apply to mental defectives.

Appeals against continuance of detention under compulsory powers

(R.C. Report, paragraphs 438-454)

46. We have reached the conclusion that the present statutory systems of appeals in Scotland, both for the mentally ill and the mentally defective,

are satisfactory. In view of our recommendation that the General Board of Control should continue to have a residual power of discharge, there is in our opinion no need for separate appellate bodies such as the Royal Commission propose for England and Wales, and we recommend that the existing rights of appeal to the sheriff should also be continued. These are the right of a mentally ill person to appeal to the sheriff against his detention at any time if he can obtain two medical certificates of his fitness for discharge; and the right of a mental defective to appeal to the sheriff against his detention at any time after he has been certified for a year.

Responsibility for documentary authority for compulsory powers

(R.C. Report, paragraphs 747-761)

47. It seems clear to us that the submission for central scrutiny in Scotland of all the documents submitted at present should not continue in future, chiefly because this process absorbs time of Medical Commissioners that could otherwise be taken up more usefully. At the same time we think it would be unfair to patients to leave the scrutiny of, for example, documents authorising detention to the staff of hospitals, who are in fact detaining the patients.

48. We recommend therefore:

(*a*) that there should be no submission for central scrutiny of documents relating to voluntary patients; and

(*b*) that documents necessary for safeguarding the interests of patients detained under compulsory powers should continue to be submitted to the General Board of Control. We have indicated the main documents in question in the Appendix; the extent and form of the documents may need overhaul, but we have not thought it necessary to consider this.

Inspection of (*a*) *hospitals and institutions and* (*b*) *boarded-out patients*

(R.C. Report, paragraphs 737-744)

49. We recommend that the Medical Commissioners of the General Board of Control should continue to have right of access to hospitals and institutions that have been approved for the reception of patients under compulsory powers. As we have indicated in paragraph 14, the Board should also continue to have access to other patients in certain circumstances. We recommend continued inspection by the Board of mental defectives and patients under guardianship and on probation and of mental defectives on licence.

Expansion of community care by local authorities

(R.C. Report, paragraphs 601-678)

50. We recognise the importance of the Royal Commission's recommendations on this subject, and we are sorry that the period within which we were asked to report was too short to allow us to devote to it the attention that it deserves. Such discussion as we had indicated that we were generally in agreement with the trend of the Royal Commission's proposals, but any worthwhile recommendations would entail much more consideration and enquiry than was possible in the time at our disposal.

51. The Committee wish to record their appreciation of the assistance they have received from Mr. Taylor and latterly Mr. Skinner, as Assessors, and from Mr. Reid as Secretary. They have all helped very materially in marshalling and focussing the considerations to be taken into account by the Committee, and Mr. Reid has had a difficult task in preparing drafts of the report following discussions which inevitably covered a wide range of topics.

JOHN DUNLOP
Chairman
(on behalf of the Committee)

March, 1958.

Note: When this report came before the Scottish Health Services Council on 2nd May, 1958, they decided that the Committee should resume work in order to consider the question of the expansion of community care by local authorities.

APPENDIX

Observations on Functions of the General Board of Control for Scotland

(1) Functions in which the Board is acting for the patient's interest to ensure the avoidance, by other bodies or persons, of improper detention and inadequate care

(*a*) **Scrutiny of documents.** In respect of patients admitted compulsorily we recommend that the General Board of Control should continue to receive in future:

(i) documents relating to compulsory admission, i.e., application form, medical certificates and sheriff's order;

(ii) notices of deaths and discharges;

(iii) extracts from the Statutory Registers of accidents and of restraint and seclusion;

(iv) certificates by medical superintendents renewing compulsory detention of mental patients.

(*b*) **Approval of applications.** We consider that the Board should not in future require to approve applications for voluntary admission to a mental hospital or applications by parents or guardians to place mental defectives under 21 under detention. We think that the Board should continue to approve applications to transfer patients admitted compulsorily from one hospital or institution to another.

(*c*) **Judicial factors.** Where in the opinion of the Board the property of any person is not duly protected because of his mental incapacity, they may approach the Lord Advocate who may apply to the Court of Session for appointment of a judicial factor to take care of the property and apply it for the owner's benefit. The Board (and the Accountant of Court) have power to report to the Lord Advocate any mismanagement by a judicial factor so appointed. We recommend that the Board should continue to have this power.

(*d*) **Power of discharge at any time.** The Board may, upon being satisfied by the certificate of two medical practitioners whom they think fit to consult on the recovery of sanity of any person, order the liberation of such person. We recommend that the Board should continue to have this power.

(2) Functions in which the Board themselves take direct executive action in relation to the patient

We think that the Board should continue to exercise the functions and powers described below:—

(*a*) the continuous power to discharge a mental defective; and

(*b*) the making of reports to the Courts on the probability of recovery of any person whose spouse has brought an action of divorce on the grounds of incurable insanity.

(3) Functions in which the Board are acting in a quasi-judicial capacity

We recommend that the Board should in future have powers, comparable to those which they have at present under the Lunacy Acts, to investigate or inquire into the treatment of mental patients or mental defectives.

(4) Managerial functions

The Board are at present responsible for the management of the State Institution for mental defectives of violent or dangerous propensities and of the State Mental Hospital. We recommend that consideration should be given to the dis-association from the Board of these managerial functions and their transfer to another central body.

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